

STREET SMART

DESCRIPTION

Street Smart is an intensive program to prevent HIV/AIDS and other sexually transmitted diseases among homeless and runaway youth (11–18 years of age) whose behaviors place them at very high risk of becoming infected.^{1,2} Street Smart is a multisession, manual-guided, small-group intervention that teaches effective behavior change, problem-solving skills, and strategies to increase safer sexual behaviors. Life circumstances define risk for some youth; being gay, runaway or homeless, or a sex offender increases the potential for risky behavior. Although Street Smart is designed for runaway and homeless youth, it can be easily adapted for youth at very high risk in other settings.

Street Smart has been packaged by CDC's Diffusion of Effective Behavioral Interventions project; information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

Goal

The goal of Street Smart is to reduce unprotected sex, number of sex partners, and substance use among runaway youth.

How It Works

The stabilization and integration of community social services for youth may be the single best predictor of safer sex and drug use behavior. When support from adults is unavailable, youth often rely heavily on peers for information. Therefore, it is essential that HIV/AIDS prevention programs establish strong working links between difference social service agencies at both the leadership and staff levels. Youth need more than just a discussion of where these services can be obtained; they need to be taken so they can personally meet the staff and become familiar with different sites and their services.

Street Smart is held in conjunction with existing services, such as group counseling, that attract youth. The program is held over a 2- to 6-week period. It consists of

- 8 drop-in group sessions (1-1/2 to 2 hours each)
- 1 individual session
- 1 group visit to a community health resource

The sessions aim to improve youths' social skills, assertiveness, and coping through exercises on problem solving, identifying triggers, and reducing harmful behaviors. Although it is preferable that clients attend every session, the program is designed so that each session stands on its own. Ideally, 6 to 10 youth attend the 8 group sessions, which are facilitated by 2 trained counselors. Specifically, CBO staff members provide 2 more opportunities for youth in the form of an individual counseling session and a trip to a relevant community health provider.

The sessions take place in small groups to provide a supportive environment for behavior change. A private session with a counselor enables each client to personally identify risk for HIV transmission and find ways to overcome his or her own barriers to safer sex. Additionally, clients can access medical care, mental health care, and referrals for individual health concerns, if needed.

The Abstinence, Be Faithful, [use] Condoms (ABC) approach can be an important component of HIV prevention for youth. Although abstinence-only interventions have not been proven effective at reducing risk for HIV, integration of the ABC message into evidence-based interventions such as Street Smart may enhance safe-behavior education for youth by offering abstinence from sex or drugs as a part of more comprehensive risk-reduction strategies.

Theory behind the Intervention

Street Smart draws on social learning theory, which describes the relationship between behavior change and a person's beliefs that he or she can change a behavior and that changing that behavior will produce a specific result. It links thoughts, feelings, and attitudes to behavior change. Beliefs about perceptions of self-efficacy and the consequences of behavior are key determinants of effective behavior change.

Research Findings

In research field trials, who completed the Street Smart group sessions reported lower rates of substance use and unprotected sex. Young women reported greater reductions in substance use and unprotected sex than did young men; African American youth reported less substance use than did youth of other ethnic groups.^{1,2}

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

Street Smart has the following 6 core elements:

- Increase clients' knowledge about
 - HIV and its transmission
 - Benefits of HIV testing and knowing one's HIV status
 - The role of stigma
 - The changing epidemiology of the epidemic
- Have clients identify peers' and partners' social norms and expectations, to increase self-efficacy.
- Have clients recognize and control feelings and emotional responses.
- Have clients identify their risk, and teach personal use of HIV/AIDS risk hierarchy.
- Use peer support to identify personal triggers to unsafe behavior.

- Build skills in problem solving and assertiveness in social situations to reduce risk for HIV/AIDS.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

Street Smart has the following key characteristics:

- Convene groups of 6 to 10 youth, male and female.
- Deliver 8 sessions (90 to 120 minutes each)
- Hold 1 individual counseling session and 1 trip to a community resource serving at-risk youth.
- Have groups meet 2 to 4 times per week.
- Create a curriculum that is highly structured with built-in flexibility so it can be individualized to particular groups of youth.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for the 8 group sessions of Street Smart are as follows:

Getting the Language of HIV and Other Sexually Transmitted Diseases

The main point of this session is to convey that knowing the facts about HIV/AIDS is essential because this knowledge allows people to protect themselves and others. Furthermore, understanding HIV/AIDS allows people to monitor their own effectiveness at implementing HIV prevention strategies. In this session, clients will use an educational game and role-playing to

- become familiar with the key characteristics of the intervention (e.g., use of tokens, “feeling thermometer”)
- learn basic information about HIV and other sexually transmitted diseases and how these diseases are transmitted
- learn their personal risk factors

Assessing Personalized Risk

The main point of this session is to use role-playing and group brainstorming to help clients figure out which of their behaviors put them at risk and which triggers lead to unsafe behaviors.

In this session, clients will

- increase familiarity with key characteristics of the intervention
- understand safer sex
- recognize personal risk behaviors
- learn which triggers increase their personal risk
- learn to set personal limits

Learning How to Use Condoms

The main point of this session is for clients to become less anxious and more comfortable talking about and using condoms. Clients will

- increase familiarity with key characteristics of the intervention
- learn and practice the correct use of male and female condoms
- increase their comfort level with condoms

Learning about the Effects of Drugs and Alcohol

The main point of this session is to use role-playing and confronting beliefs so clients can identify how drugs and alcohol affect their thinking and choices. Clients will learn

- how alcohol and drugs affect the ability to practice safer sex
- the pros and cons of substance use
- how drugs and alcohol can affect a person
- about addiction and triggers for substance use
- skills for breaking the cycle of addiction

Recognizing and Coping with Feelings

The main point of this session is to use role-playing and the “feeling thermometer” to help clients identify different coping styles for tough situations and to solve problems. Clients will

- learn skills for coping with stressful feelings
- become familiar with the SMART method for coping and problem-solving. SMART stands for
 - State the problem
 - Make a goal
 - Actions you can take
 - Reach a decision
 - Try and review it
- learn relaxation techniques

Negotiating Effectively

In this session, clients will

- review key characteristics of the intervention
- learn how to stand up for their personal values
- use interpersonal problem-solving and role-playing to
 - explore personal sexual values
 - learn to deal with peer pressure
 - develop problem-solving skills
 - learn to communicate effectively using “I” statements

Doing Self-Talk

In this session, clients engage in educational games and exercises to learn how to use their thoughts and self-talk to help them make safer decisions. Clients will

- review key characteristics of the intervention
- learn how to think through positive and negative events to facilitate protective actions
- learn to break the cycle of negative thoughts
- practice thinking positive thoughts about themselves
- learn helpful self-talk to keep themselves safe

Practicing Safer Sex

In this session, clients engage in a small-group discussion and create a media message (music video, soap opera, commercial) to figure out why they engage in risky behaviors and to learn how to argue against their rationalizations. Clients will

- review key characteristics of the intervention
- figure out personal risk in unclear sexual situations
- learn to combat rationalizations
- strategize how to deal with slip-ups
- apply what they have learned to the media message they create

ADAPTING

Street Smart was field tested among homeless and runaway youth in homeless shelters the Los Angeles, California area. Most of the clients were black and Latino youth. Street Smart could be adapted for use in other venues and among other race or ethnicity groups.

Street Smart could be translated into Spanish, and some of the language could be paraphrased for clients who have literacy challenges.

RESOURCE REQUIREMENTS

People

To effectively implement Street Smart, CBOs should have a project coordinator, 2 trained adult facilitators with the required skills and experience, and 1 staff person with skills to conduct the evaluation of the intervention.

Street Smart facilitators should have extensive experience working with youth, especially at-risk youth. Facilitators should be aware that some participating youth may already have been adversely affected by the HIV/AIDS epidemic and should be trained with regard to counseling about HIV/AIDS. The Street Smart implementation manual has guidance on things facilitators need to know and tips for successful implementation of the intervention.

Facilitators

- should include at least 1 with experience in youth group facilitation
- must both complete Street Smart training conducted by a qualified capacity building assistance provider
- should include at least 1 with a degree in counseling or 1 of the behavioral sciences (e.g., psychology, sociology, anthropology)

Facilitators should understand

- the underlying principles of the program
- the theories behind the intervention

- how youth operate (e.g., that few youth know how to apply safer-sex practices, that adolescence is a time of experimentation, and that having been sexually abused increases the risk that youth will practice unsafe sex)

Facilitators need to be skilled in

- reinforcing positive behaviors
- labeling feelings
- encouraging active participation
- learning effective coping strategies
- creating concern over unsafe behaviors
- encouraging group cohesion of appropriate norms for behavior
- using role-playing activities
- understanding group dynamics
- relating the intervention content to the lives of the youth
- rewarding positive behavior
- being supportive and nonjudgmental
- giving praise
- building on strengths

Space

Street Smart needs a private room that is inviting, comfortable, safe, and large enough for the groups.

Supplies

Street Smart needs a VCR, TV, video camera, and people to operate the equipment.

Other

Youth participating in Street Smart also need

- community resources to support the desired behavior (safer sex)
- access to HIV counseling, testing, and referral; health care; alcohol and drug treatment; legal aid; advice on how to take the general equivalency diploma (GED) examination; help in enrolling in athletic programs; and housing
- transportation to community agencies and centers where they can personally meet the staff and learn about what they offer
- enough notice to be able to change their schedules to fit the program
- a telephone number they can call with questions about the program
- snacks

The CBO should also have

- attractive and easily understood promotional materials
- enough supplies (e.g., nametags, tissues, paper, pens and pencils, handouts) for all clients
- clear, correct, and understandable visual aids
- a suggestion box
- strong relationships with different social service agencies at both the leadership and staff levels

- access to at-risk youth (CBOs implementing Street Smart must serve at-risk youth or have established relationships with organizations serving at-risk youth [e.g., juvenile detention centers, homeless shelters, drop-in youth centers, youth outreach centers]). CDC does not endorse Street Smart for in-school programs.
- access to community resources for youth
- CBO commitment to
 - have adult facilitators complete Street Smart intervention training (3 full days)
 - implement the entire program
 - adapt program with fidelity to core elements
- adequate funds or creative community resources to provide incentives for clients (e.g., food or small prizes for the activities and games)
- system to refer clients to additional services (e.g., counseling) if required

RECRUITMENT

The population recruited for Street Smart is youth at very high risk. The intervention can be presented to runaway and homeless shelters as part of their best practices that benefit clients. Incentives, when possible, can play a role in recruitment. General recruitment into the 8 Street Smart sessions can include word of mouth, peer-to-peer recruitment, and other marketing strategies, including flyers, newsletters, and special events.

Street Smart was designed for and tested among a very specialized group of homeless and runaway teens: those who are the most marginalized and desperate and those living on the streets for some length of time. Therefore, Street Smart may not be appropriate for all homeless and runaway teens. For example, very young children (aged 10–12) who have been homeless or who have run away from home fewer than 6 months may not be ideal populations for this intervention. Young persons, new to the streets, may not have adopted many of the risk behaviors considered in the intervention. Before implementing Street Smart, CBOs should consider screening youth to ascertain extent of risk behaviors and dividing younger children and those who are not sexually active into groups with similar backgrounds and experiences.

Review Recruitment in this document to choose a recruitment strategy that will work in the setting in which the CBO plans to implement Street Smart.

POLICIES AND STANDARDS

Before a CBO attempts to implement Street Smart, the following policies and standards should be in place to protect clients and the CBO:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO's responsibility and the clients' rights. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client's record.

Legal and Ethical Policies

CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization's responsibilities if a client receives a positive HIV test result and the organization's potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

CBOs must be prepared to refer clients as needed. For clients who need additional assistance in decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as partner counseling and referral services and other health department and CBO prevention programs.

Volunteers

If the CBO uses volunteers to assist with or conduct this intervention, then the CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers.

CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing Street Smart:

CBOs

Implementation Plan

Developing a comprehensive implementation plan will facilitate understanding and buy-in from key stakeholders and will increase the likelihood that the intervention runs smoothly.

Leadership and Guidance

Quality assurance also requires that someone at the CBO provides hands-on leadership and guidance for the intervention, from preparation through institutionalization. Also needed is a decision maker at the CBO who will provide higher level support, including securing resources and advocating for Street Smart, from preparation to institutionalization.

Fidelity to Core Elements

Throughout implementation, it is necessary to determine whether staff members are delivering Street Smart with fidelity to the 4 core elements. A fidelity checklist is available in the intervention kit and can be used as a quality assurance tool. It is also necessary to identify and address any issues to ensure that the intervention is meeting the needs of CBO clients and staff.

Clients

Quality assurance is also present in the protocol used when linking youth and escorting youth to community resources. Community resource staff can be paired with youth when touring the resource and its services. CBOs should ensure that these community resource staff members follow up and invite youth back and provide feedback to the CBO with regard to the visits.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-

based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

Kelly JA, Heckman TG, Stevenson LY, et al. Transfer of research-based HIV prevention interventions to community service providers: fidelity and adaptation. *AIDS Education and Prevention*. 2000;12 (Suppl A):87–98.

Moon MW, McFarland W, Kellogg T, et al. HIV risk behavior of runaway youth in San Francisco: age of onset and relation to sexual orientation. *Youth and Society*. 2000;32(2):184–201.

Rotheram-Borus MJ, Noelle L. Training facilitators to deliver HIV manual-based interventions to families. In: Pequegnat W, Szapocznik J. (eds.) *Working with Families in the Era of HIV/AIDS*. New York: Sage; 2000.

Rotheram-Borus MJ, Song J, Gwadz M, Lee M, Van Rossem R, Koopman C. Reductions in HIV risk among runaway youth. *Prevention Science*. 2003;4(3):173–187.

REFERENCES

1. Rotheram-Borus MJ, Van Rossem R, Gwadz M, Koopman C, Lee M. *Reductions in HIV Risk Among Runaway Youths*. Los Angeles, Calif: University of California, Department of Psychiatry, Division of Social and Community Psychiatry; 1997.

2. Rotheram-Borus MJ, Koopman C, Haignere C, Davies M. Reducing HIV sexual risk behaviors among runaway adolescents. *Journal of the American Medical Association*. 1991;266:1237–1241.